: "Hillside Hospital: Physician-Led Planning" (Part A)

1. Apply Porter's Five Forces framework to Hillside Hospital, i.e., do not simply reproduce the generic Five Forces analysis for the hospital industry
    a. Be specific about the players/entities Hillside faces in each of the forces/categories.
    b. Discuss the strength of each force and significant players within each force.
    c. Which force or forces are most important for Hillside to counteract at this time?

2. Based on your analysis prepared for question 1, evaluate the Service Line Strategies and Non-Service Line Specific Strategies articulated in the 2012 Strategic Plan. Which are most important to pursue? Should any be eliminated? Explain your answer.

3. What are the Pros/Cons of Hillside Hospital pursuing the MAP (i.e., establishing a Medical Advisory Panel and implementing Physician-Led Clinical Priority Setting)?

4. What would be the next best alternative to pursuing the MAP?

5. Which should Hillside do (pursue MAP or your best alternative)?

Hospital Industry Strategic Analysis & Recent Trends

HSM 430

March 22, 2022

Samuel Ogie

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Agenda

1. Creating and capturing value.
2. Overview of a not-for-profit hospital.
3. Framework for strategic analysis.
4. Recent trends affecting the hospital industry

2

2

What is Strategy?

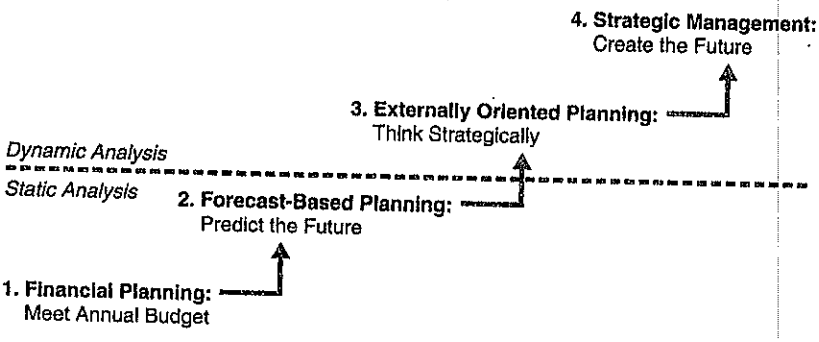
"Strategy can be defined as the determination of the basic long-term goals and objectives of an enterprise, and the adoption of courses of action and the allocation of resources necessary for carrying out those goals." – Alfred D. Chandler Jr.

Is this definition complete and clear?

"The ultimate objective of strategic decision-making is to realize sustained [economic] profits. To achieve this objective, managers must devise ways to *create and capture value*." – BSZ, p. 259.

We want to move beyond static analysis

EXHIBIT 1.6 Four Phases of Strategy.

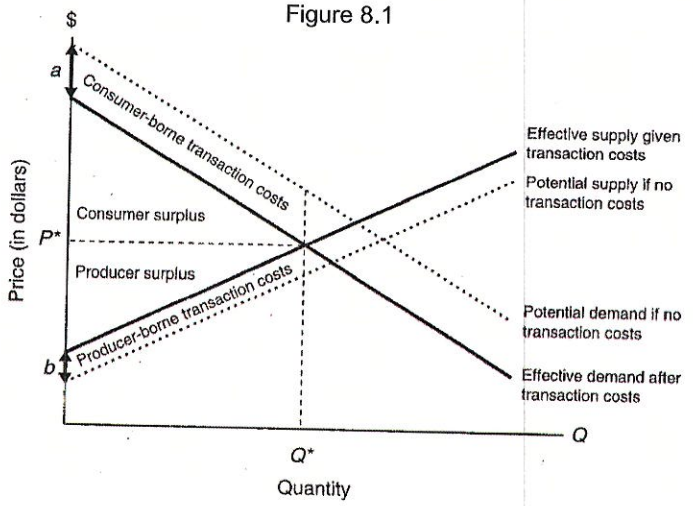


Source: Ghemawat, Strategy and the Business Landscape, 3rd Edition, p. 12, Prentice-Hall, 2010.

There are four ways to create value.

1. Lower production costs (or producer transaction costs).
2. Reduce consumer transaction costs.
3. Increase demand (e.g., improving quality, lower price of complements, raise price of substitutes).
4. Develop new products or services.

Figure 8.1



Source: BSZ 6th Ed., p. 260

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Who captures the value?

1. Firm?
2. Employees?
3. Customers?
4. Competitors?
5. Suppliers?

Depends on:

- Market Power
- Superior factors of production (scarce resources).

All participants in the market have agency and will respond to any action by others.

6

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Who captures the value?

1. Firm?
2. Employees?
3. Customers?
4. Competitors?
5. Suppliers?

What does it mean if the "firm" captures value? Who is the firm? How can employees capture value?

All participants in the market have agency and will respond to any action by others.

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Why do hospitals exist?

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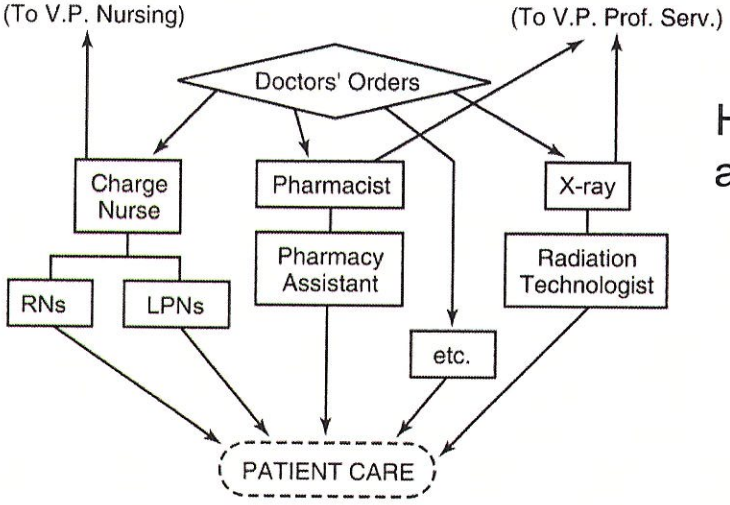
FIGURE 8.3 The doctor directs the activity.

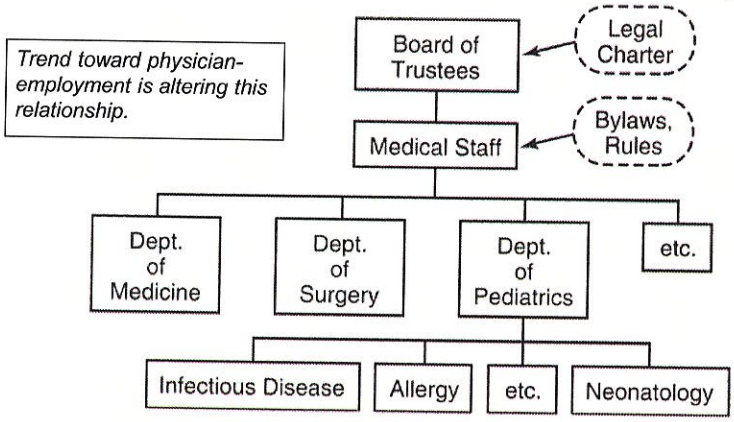


Hospitals serve as a "job shop."

Source: Phelps, *Health Economics*, Fifth Edition, 2013.

The medical staff is independent of the hospital.

FIGURE 8.2 Organization of the medical staff.



Source: Phelps, *Health Economics*, Fifth Edition, 2013.

The majority of hospitals are not-for-profit (NFP).

Table 89. Hospitals, beds, and occupancy rates, by type of ownership and size of hospital: United States, selected years 1975–2015

[Data are based on reporting by a census of hospitals]

Type of ownership and size of hospital	1975	1980	1990	2000	2005	2010	2013	2014	2015
Hospitals					Number				
All hospitals	7,156	6,965	6,649	5,810	5,756	5,754	5,686	5,627	5,564
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For profit	775	730	749	749	868	1,013	1,060	1,053	1,034
State-local government	1,761	1,778	1,444	1,163	1,110	1,068	1,010	1,003	983
6–24 beds	299	259	226	288	370	424	469	486	499
25–49 beds	1,155	1,029	935	910	1,032	1,167	1,186	1,168	1,146
50–99 beds	1,481	1,462	1,263	1,055	1,001	970	959	934	916
100–199 beds	1,363	1,370	1,306	1,236	1,129	1,029	996	1,013	983
200–299 beds	678	715	739	656	619	585	571	536	535
300–399 beds	378	412	408	341	368	352	334	328	322
400–499 beds	230	266	222	182	173	185	183	188	177
500 beds or more	291	317	285	247	244	273	277	273	284

Source: National Center for Health Statistics, CDC, U.S. Department of Health and Human Services.

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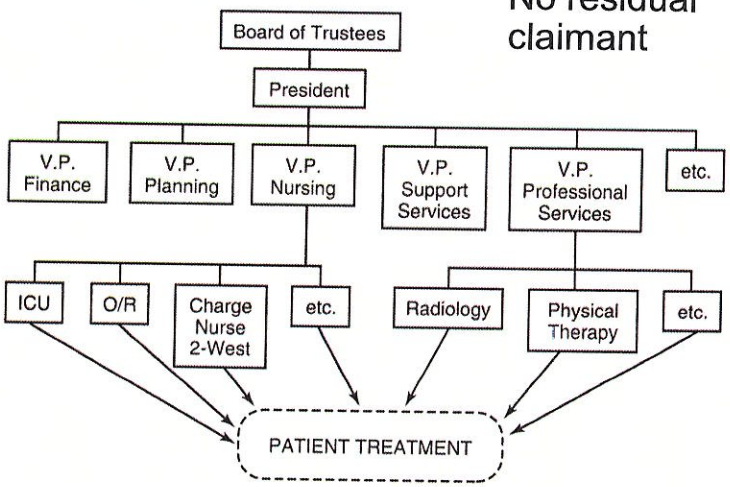
NFP hospitals have no owner.

FIGURE 8.1 Hospital organizational structure.

No residual claimant



Source: Phelps, *Health Economics*, Fifth Edition, 2013.

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So, who is the residual claimant (i.e., who appropriates the value)?

- Patients/community? This is the justification for not-for-profit status. Patients and the community can not appropriate value directly.
- Board members? Ultimately in control, but not paid and have no equity interest. Not clear how they can appropriate value.
- Physicians? They control all patient care, including referrals and admissions. Certainly possible to appropriate value.
- Nursing staff/employees? Cannot appropriate value directly. Must influence the community, board, and administrators.
- Administrators? Make the day-to-day operating decisions and influence the flow of information to the board.

https://charity.lovetoknow.com/charitable-organizations/facts-about-past-united-way-corruption-scandals

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The board's control relies on oversight.

- Board members have neither the expertise nor the time to make the myriad decisions necessary to run a hospital.
- Board conducts formal reviews of operating budget, capital budget, strategic plan, and CEO performance/compensation.
  - Operating budget approved annually and tracked quarterly.
  - Capital budget approved with operating budget. All unplanned expenditures above a threshold require board approval.
  - CEO performance reviewed annually and compensation benchmarked.
- Board may periodically review quality and patient satisfaction and will examine in detail JCAHO and Dept. of Health review results.
- Otherwise, CEO has great latitude for decision-making and the board generally takes the recommendation of the CEO.

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All parties try to influence the CEO and board.

- Asymmetric knowledge and incentives may lead to the CEO "playing" the board.
  - CEO controls the flow of information to the board and may package it to lead to his preferred decision. Savvy board members watch for this.
- CEO will also try to manage composition of the Board.
- Physicians, nurses, and others try to influence board and CEO preferences as well as composition of the board. Done publicly and privately.

Framework for Strategic Analysis

- Mapping the Business Landscape
- The five forces framework
  - Degree of rivalry
  - Threat of entry
  - Threat of substitutes
  - Buyer power
  - Supplier Power

Mapping the Business Landscape

Need to understand how an industry works before assessing individual companies' strategies and options

1. Gather information.
2. Draw the boundaries (vertical, horizontal, geographic scope).
3. Identify groups of players (five forces, value net,).
4. Understand group-level bargaining power.
5. Think dynamically.
6. Respond to/shape the business landscape.

Source: Ghemawat, Strategy and the Business Landscape, 3rd Edition, p. 31, Prentice-Hall, 2010.

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Drawing the Boundaries

- Definitions like "managed care industry" typically too broad
- Dimensions of choice:
  1. "Horizontal" = breadth of product segments
     - Pharma & medical devices: whole industry or specific therapeutic categories?
  2. (sometimes) "Vertical" = what stages of production chain?
     - Pharma: look at whole chain or split up in R&D and production/marketing/distribution?

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Drawing the Boundaries (cont'd)

3. Geographical
   - Hospitals: typically local market
   - HMOs: local or regional or national?
   - Drugs: national or world market?

- Right market definition depends on what problem you're dealing with, regulation, etc.
- Then: look at substitute products and services. An excellent substitute is really your competitor, not a substitute.
- There isn't necessarily a correct boundary. Key is to be clear and consistent.

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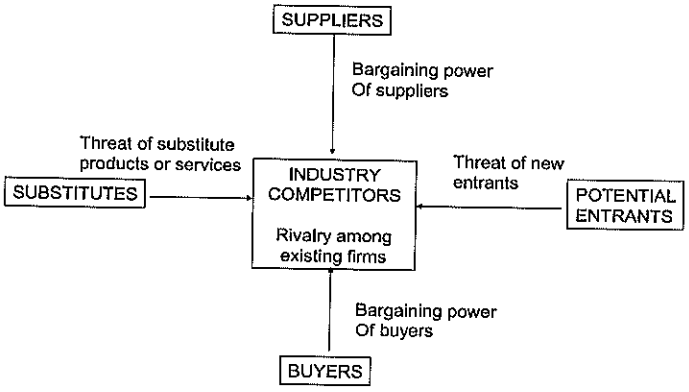
Porter's Five Forces



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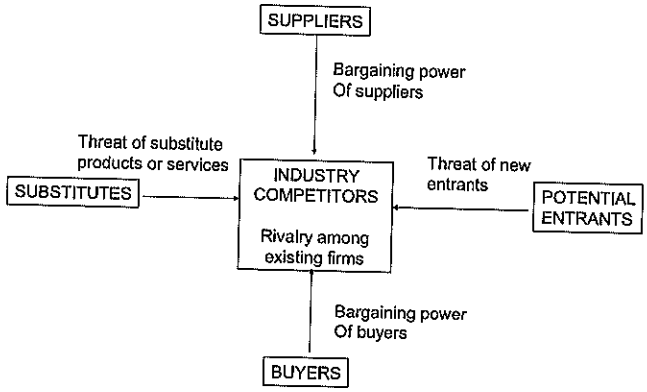
Hospital Industry Five Forces Analysis



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To what extent do substitutes constrain industry pricing?

- Close substitutes will reduce the industry's ability to raise prices.
  - Hospitals: outpatient care provided in physician's office, drugs, etc.
- Substitutes can be completely different products:
  - Preventive care; eyeglasses and laser surgery
- Main point: don't forget to think about these!
  - Don't over-invest in services if close substitutes may become available.
  - Lobby to reduce the value of substitutes.

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To what extent can sellers charge prices above their costs?

- Different groups of suppliers differ in power.
  - Pharma
  - Medical devices
  - MDs
  - Employees

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Aggressive incumbents and barriers reduce the threat of entry.

Factors increasing chance of aggressive response to entry:

- Reputation – previous aggressive competition
- Capability (financial, production capacity, relationships with customers, etc.)
- Need to maintain volume – economies of scale
- Slow industry growth

Barriers to Entry

1. ***Economies of scale***
2. Network effects
3. Switching costs
4. ***Capital requirements***
5. Incumbency advantages
6. Distribution channels
7. ***Restrictive government policy***

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EOS, capital requirements, and NFP industry structure interact to form a significant barrier.

- Economies of scale are difficult to isolate in hospitals because scale is almost always associated with increasing scope, however, EOS clearly exist as hospitals' *raison d'être* is to aggregate demand.
- Hospital care is frequently high-tech, and in particular, profitable services use expensive equipment and facilities. Cost estimates range $1m to $2m per bed.
- The vast majority of hospitals choose to be NFP which precludes raising equity capital. NFP offers significant tax advantage and is linked to perception of quality.

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What is Certificate of Need?

Certificate of need (CON) programs are state regulations intended to restrain health care facility costs and coordinate planning of new services and construction. Advocates argue that CON regulations:

- Target funds where they will be used most effectively, reducing health care expenditures.
- Improve quality of care.
- Distribute services to underserved areas.

All 50 states have had CON at one point, but 16 states have repealed their laws.

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How is CON justified?

Assumption: Excess capacity (in health care facilities) leads to greater health care expenditures via two mechanisms:

- Providers with unused capacity raise prices to cover fixed costs.
- Available capacity leads to over-utilization.

Government pays for a large proportion of health care, so government should prevent excess capacity.

How does this assumption compare to our understanding of economics?

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Normal Rules Don't Apply?

- We expect excess capacity to increase competition, but CON advocates counter that normal market rules don't apply to health care
  - Health services are "ordered" for patients by physicians; patients do not shop for these services as they do for other commodities
- Someone (patient or physician) is still selecting one service provider over another, so why wouldn't competition drive down price?
  - Third-party payment – the person choosing the service provider doesn't bear the cost of the decision.
- How are payment decisions made?
  - Government payers set price using pps - no longer cost-plus
  - Managed care negotiates payment rates upfront

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What is meant by over-utilization?

- Demand inducement by physicians. Key is limiting physicians' ability to profit from inappropriately influencing demand.
- Demand beyond what "experts" deem appropriate.
  - This justification for CON implicitly endorses government rationing of health care through restricted access.

What does the evidence say about the efficacy of CON regulation in reducing the health care expenditures?

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CON Reality: A barrier to entry (and little else).

- Empirical studies generally agree that CON regulations:
  - Are successful in "controlling the diffusion of selected clinical services… and the number of new programs."
  - Are ineffective in controlling health care expenditures.
- 2004 FTC & DOJ study *Improving Health Care: A Dose of Competition* concluded "CON programs are generally not successful in containing health care costs and that they pose anticompetitive risks."
- The evidence related to CON impact on quality is mixed and inconclusive.

Sources: Conover, C., "Health Care Regulation: A $169 billion Hidden Tax, Policay Analysis No. 527, The Cato Institute, October 2004; "Improving Health Care: A Dose of Competition," FTC and DOJ, July 2004; Sarrazin, M., et all., "Hospital volume and outcome after coronary angioplasty: Is there a role for certificate of need regulation?", American Heart Journal, 2004; 147:383-5.

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Internal rivalry: when hospitals compete, what are they trying to gain?

- Profitable patients
  - Payer groups (not just Medicaid); see discussion of managed care.
  - Disease category/treatment modality
- Medical and other clinical staff to treat patients
  - Will discuss competition for/with physicians next session.

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Market and cost structure are key factors in rivalry.

- More firms in the business leads to lower prices.
  - Example: mergers of hospitals on Chicago's North side have led to price increases of 20% or more
  - Exception: if consumers don't care about price, e.g., hospital care before Medicare IPPS. More hospitals → higher prices.
- Relative sizes of firms – a "big dog" can impose rules on the pack.
- Low growth – competitors try to "steal" market share.
- Large steps in capacity – leads to overcapacity.
- High fixed cost/low marginal cost – temptation to cut price to marginal cost (fixed costs are quasi-sunk costs).
- High exit barriers – e.g., poor salvage value for assets (specific assets in BSZ text).

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Extreme version of rivalry: The Bertrand Trap

- Suppose customers care only about price
- Whoever has the lowest price gets all of the business
- Undercut competitors to get all of the business with nearly the same margin
- Equilibrium prediction: prices = MC
  - With constant MC: zero profit, or even losses if also fixed costs

What can they do?

1. Anything that makes buyers less likely to switch to another seller if you raise price
2. Coordinate on prices (i.e., collusion)
3. In some industries: avoid excess capacity

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How to avoid the Bertrand Trap?

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How to avoid the Bertrand Trap?

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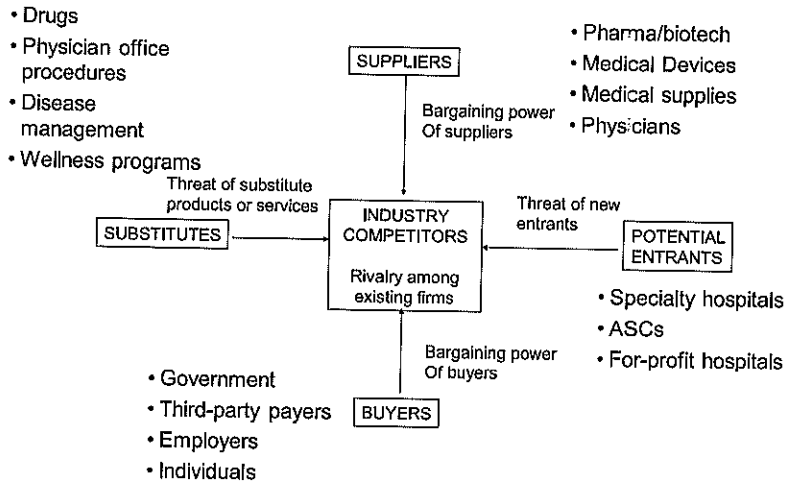
Hospital Industry Five Forces Analysis



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Sometimes, a 6th (positive) force: Complements

- Due to Brandenburger and Nalebuff, *Coopetition* (1995)
- Producers of complements for your product can increase your business! Classic example: Microsoft and Intel
- In health care, mainly in form of parties making referrals/ recommendations without being buyers
  - Referring physicians for hospitals
  - Physicians' recommendations for equipment purchases
  - Imaging technology and demand for surgery
- Want to keep substitutes (competitors) out, but want to bring complement(or)s in!

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What strategies do hospitals employ?

- Merger (market power)
  - Is a partner necessary? Why?
  - With which organization should we partner?
- Differentiation – quality, service, technology
- Location
  - In which communities should we locate?
    - Growth
    - Demographic characteristics (e.g., insurance coverage, use of health care services, etc.)
    - Current or expected presence of competitors
  - Does our Mission require our presence in any communities?

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What strategies do hospitals employ?

- "Physician-hospital alignment"
  - Responsiveness to concerns
  - Inclusion in decision-making
  - Operational efficiency
  - Joint ventures
  - Purchasing physician practices
- Nurses' "employer of choice"
- Lobbying
  - For/against CON
  - Insurance market regulation
  - Physician ownership of facilities

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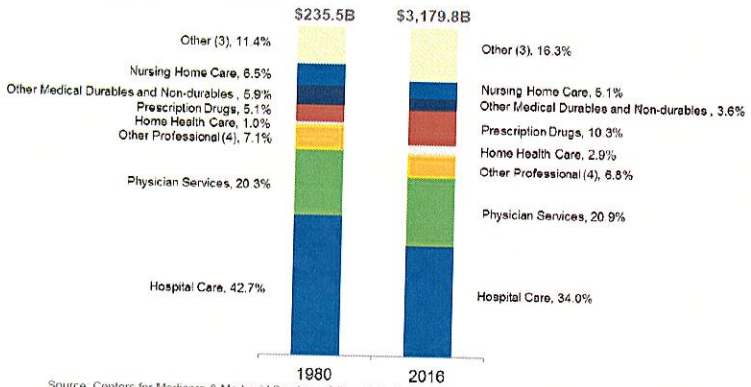
TRENDWATCH CHARTBOOK 2018
Trends in the Overall Health Care Market

Chart 1.5: National Expenditures for Health Services and Supplies(1) by Category, 1980 and 2016(2)



Source: Centers for Medicare & Medicaid Services, Office of the Actuary. Data released December 6, 2017.
(1) Excludes medical research and medical facilities construction
(2) CMS completed a benchmark revision in 2009, introducing changes in methods, definitions and source data that are applied to the entire time series (back to 1960). For more information on this revision, see http://www.cms.gov/nationalhealthexpenddata/downloads/benchmark2009.pdf.
(3) "Other" includes net cost of insurance and administration, government public health activities, and other personal health care
(4) "Other professional" includes dental and other non-physician professional services

American Hospital Association.

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Structure of U.S. hospital industry is different than you would expect.

U.S. Community Hospitals, 2015		
Number of Beds	**Number of Hospitals**	**Percent of Total**
<100	2,561	52.7%
100-199	983	20.2%
200-499	1,034	21.3%
>=500	284	5.8%

Greater Rochester Acute Care Hospitals (2018)	
Hospital	**Acute Care Beds**
Strong Memorial	823
Rochester General	516
Unity	283
Highland	247
F.F. Thompson	113

Nearly 1/3 of hospitals are fewer than 50 beds!

Sources: National Center for Health Statistics; American Hospital Association.

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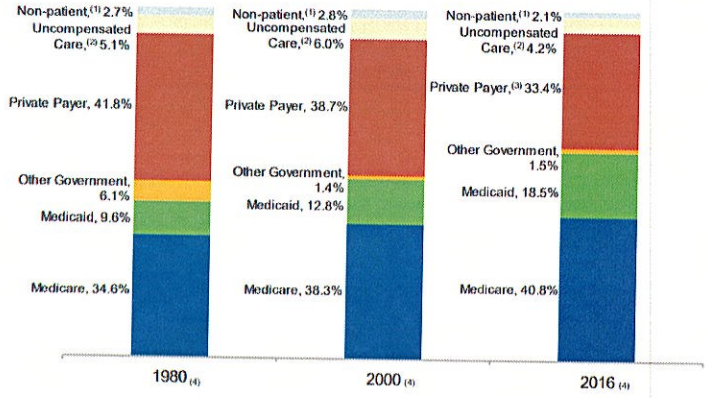
Patients with government funded insurance account for the majority of hospital care.

Chart 4.5: Distribution of Hospital Cost by Payer Type, 1980, 2000, and 2016



Source: Analysis of American Hospital Association Annual Survey data, 2016, for community hospitals.

(1) Non-patient represents costs for cafeterias, parking lots, gift shops and other non-patient care operating services and are not attributed to any one payer.

(2) Uncompensated care represents bad debt expense and charity care, at cost.

(3) Private payer formulas were updated in 2014 to account for the change in bad debt calculations, which is now reported as a deduction from revenue rather than a expense.

(4) Percentages were rounded, so they do not add to 100 percent in all years.

American Hospital Association

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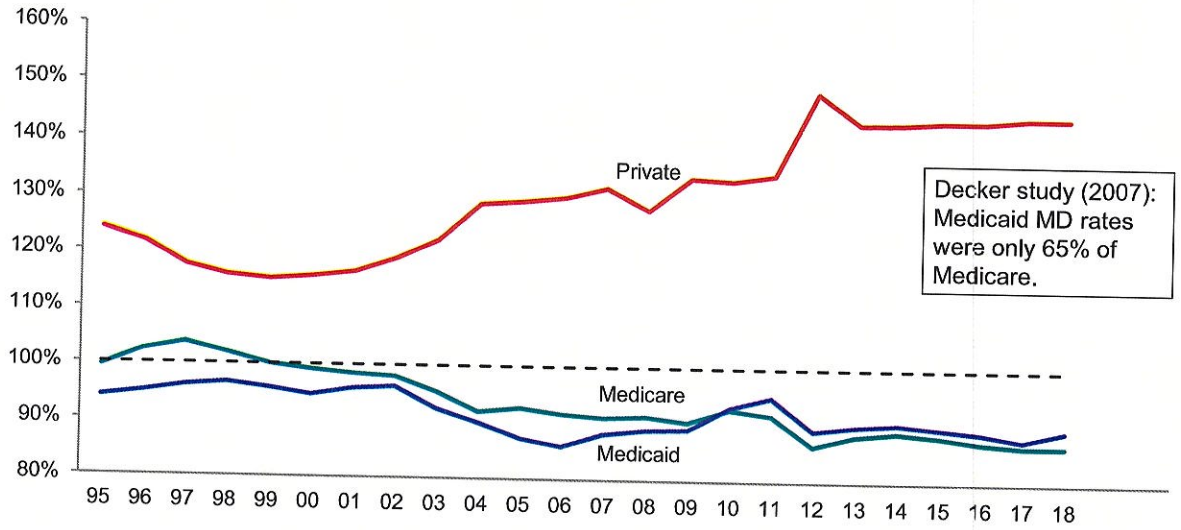
But, government underpays providers…



Source: Analysis of American Hospital Association Annual Survey data, 2018, for community hospitals.

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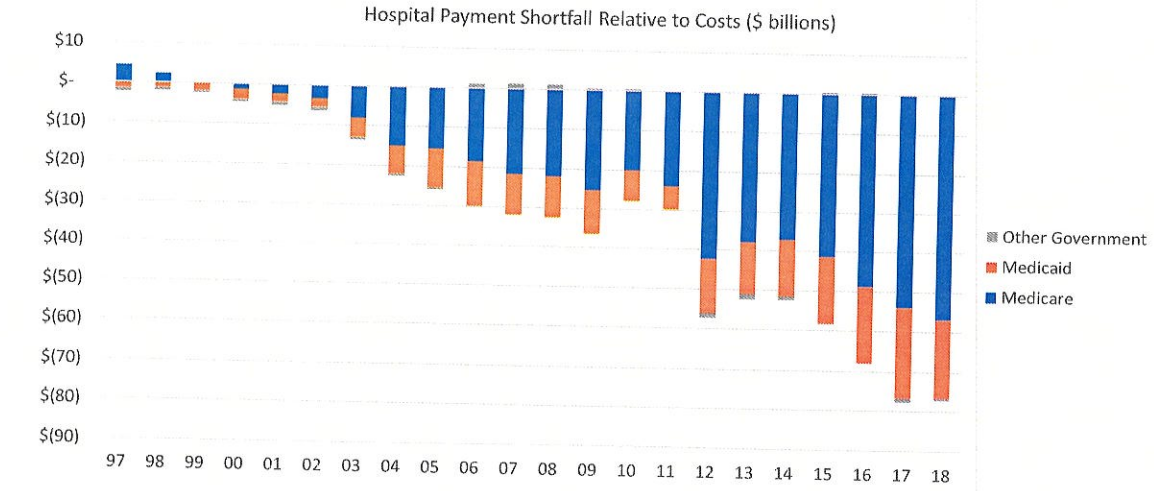
…shifting billions of dollars in costs to private payers.



Source: Analysis of American Hospital Association Annual Survey data, 2018, for community hospitals.

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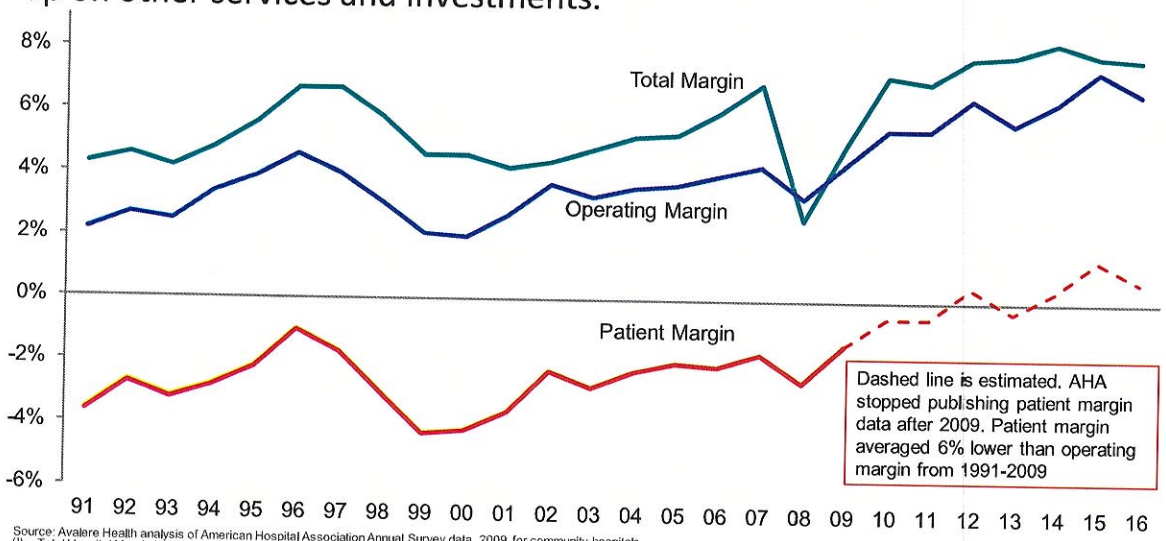
Hospitals lose money on patient care (or recently break even) and make it up on other services and investments.



Source: Avalere Health analysis of American Hospital Association Annual Survey data, 2009, for community hospitals.
(1) Total Hospital Margin is calculated as the difference between total net revenue and total expenses divided by total net revenue.
(2) Operating Margin is calculated as the difference between operating revenue and total expenses divided by operating revenue.
(3) Patient Margin is calculated as the difference between net patient revenue and total expenses divided by net patient revenue.

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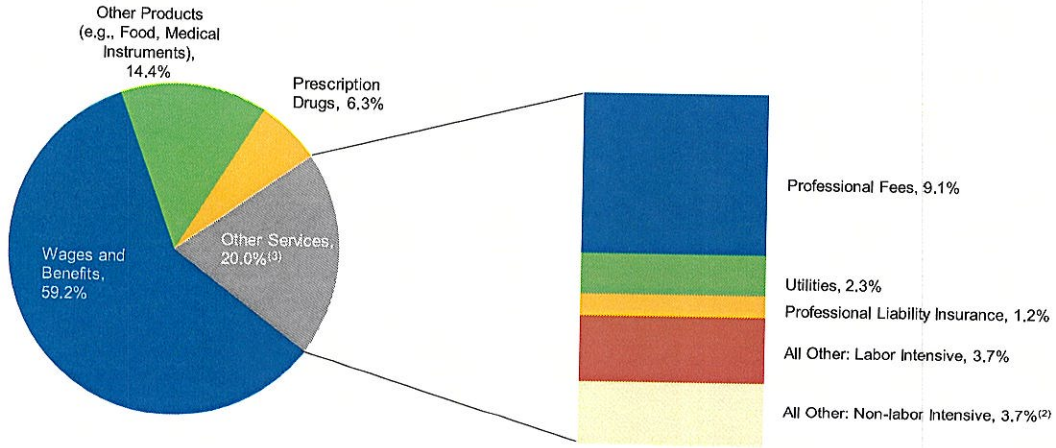
Wages and benefits are the large majority of hospital costs.



Source: AHA analysis of Centers for Medicare and Medicaid Services data, using base year 2010 weights.
(1) Does not include capital.
(2) Includes postage and telephone expenses.
(3) Percentages were rounded, so they do not add to 20 percent.

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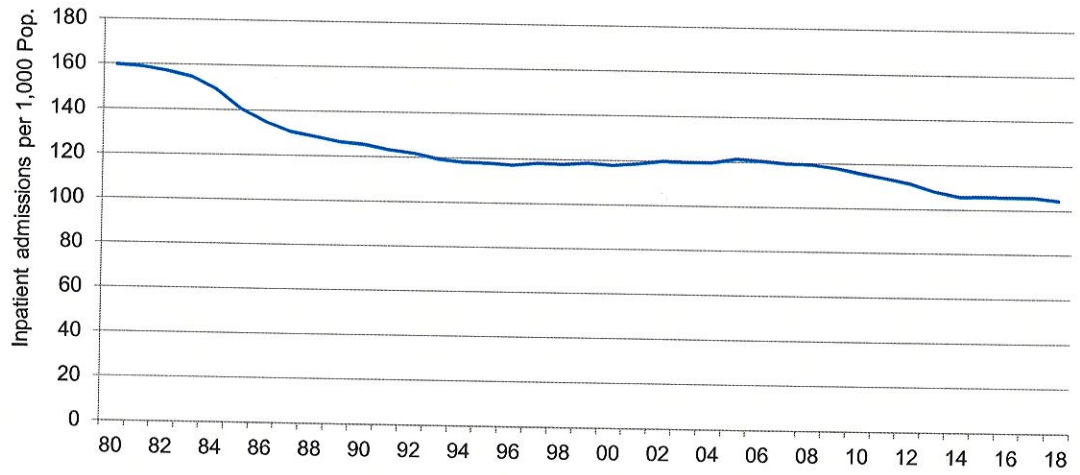
Hospital admission rates declined dramatically in the 80s.



Source: Analysis of American Hospital Association Annual Survey data, 2018, for community hospitals.

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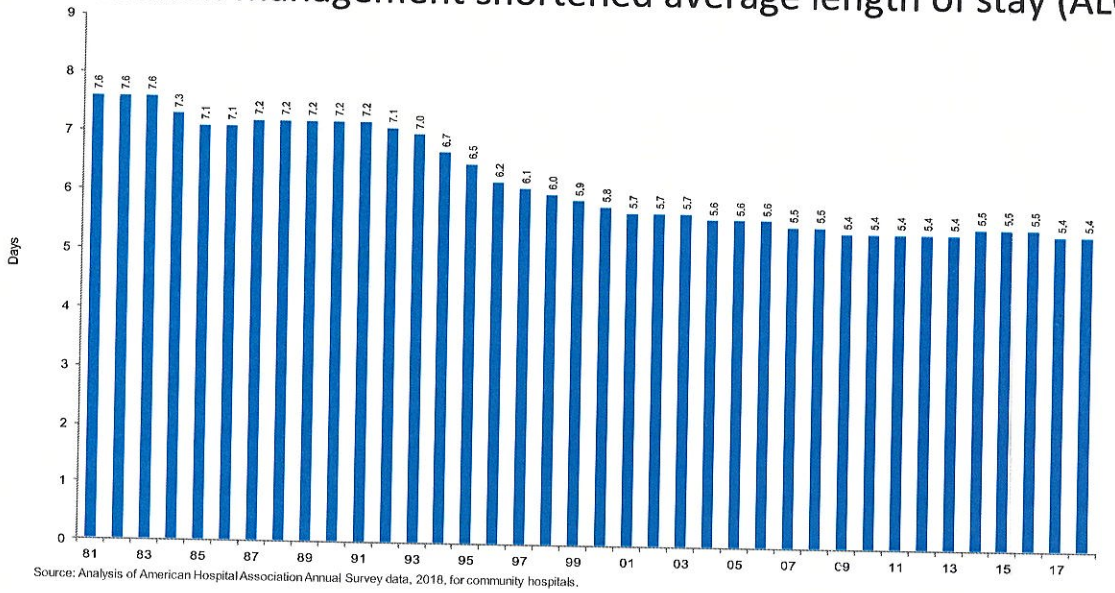
Utilization management shortened average length of stay (ALOS).



Source: Analysis of American Hospital Association Annual Survey data, 2018, for community hospitals.

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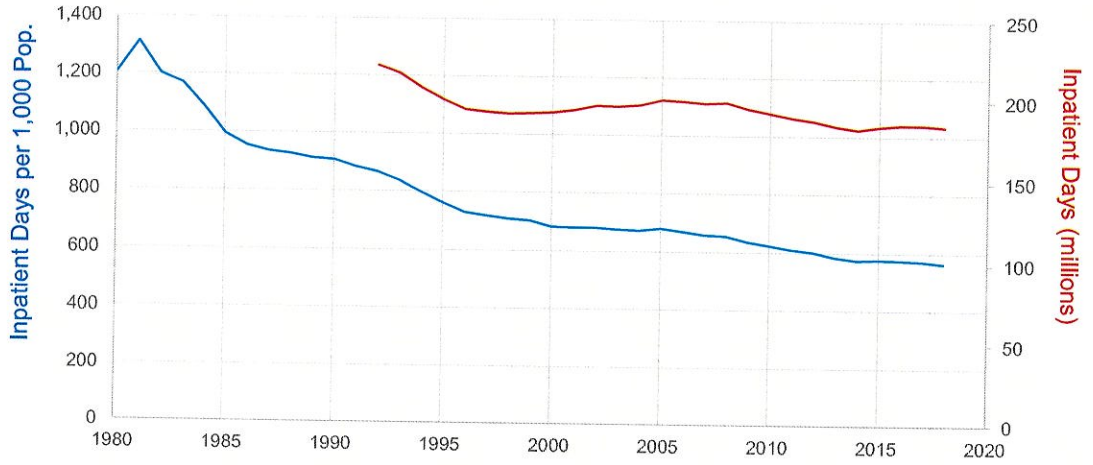
People spend much less time in the hospital.



Source: Analysis of American Hospital Association Annual Survey data, 2018, for community hospitals.

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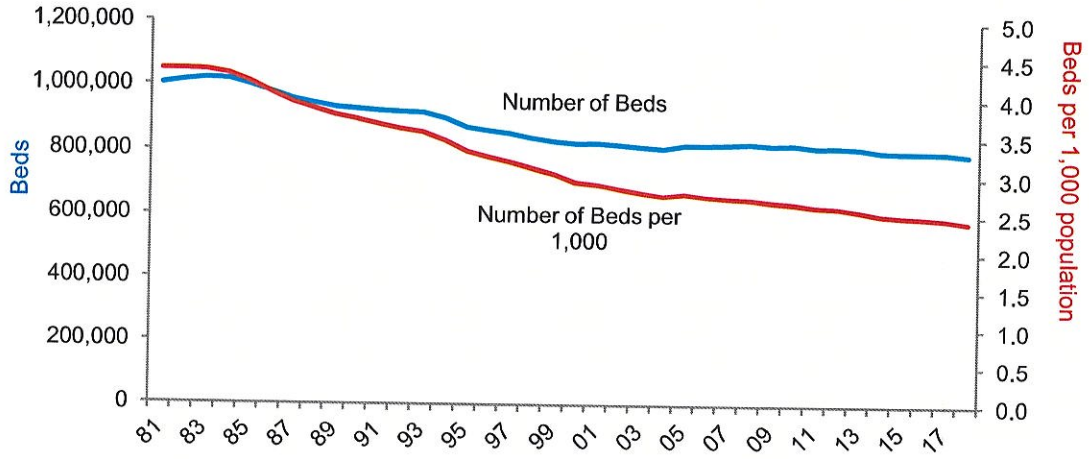
Hospitals responded by decreasing capacity.



Source: Analysis of American Hospital Association Annual Survey data, 2018, for community hospitals.

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Mid-size hospitals have born the brunt of closures.

Table 89. Hospitals, beds, and occupancy rates, by type of ownership and size of hospital: United States, selected years 1975–2015

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For profit	775	730	749	749	868	1,013	1,060	1,053	1,034
State-local government	1,761	1,778	1,444	1,163	1,110	1,068	1,010	1,003	983
6–24 beds	299	259	226	288	370	424	469	486	499
25–49 beds	1,155	1,029	935	910	1,032	1,167	1,186	1,168	1,146
50–99 beds	1,481	1,462	1,263	1,055	1,001	970	959	934	916
100–199 beds	1,363	1,370	1,306	1,236	1,129	1,029	995	1,013	983
200–299 beds	678	715	739	656	619	585	571	536	535
300–399 beds	378	412	408	341	368	352	334	328	322
400–499 beds	230	266	222	182	173	185	183	188	177
500 beds or more	291	317	285	247	244	273	277	273	284

Market is shifting to large hospitals. >500 bed hospitals have increased in number and size. Critical access hospital designation has bolstered <50 beds.

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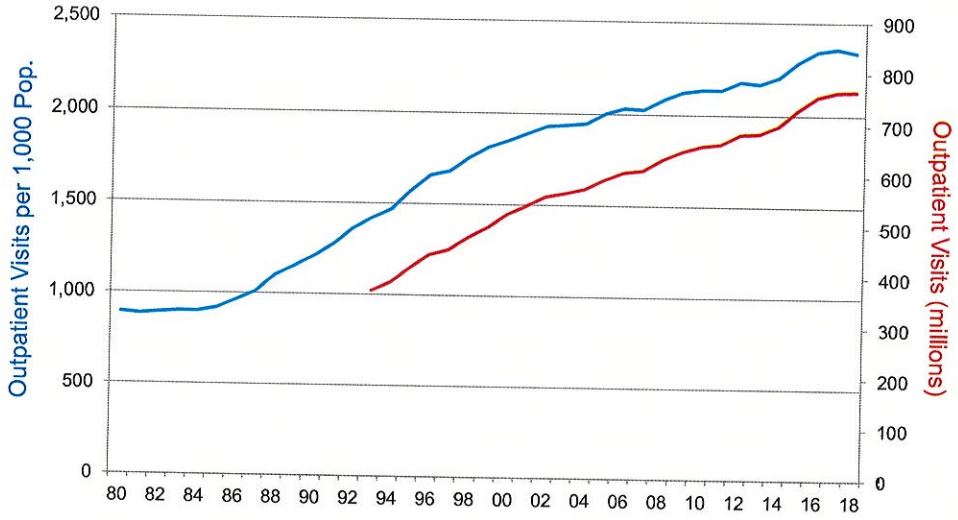
Patients get more care in an outpatient setting.



Source: Analysis of American Hospital Association Annual Survey data, 2018, for community hospitals.

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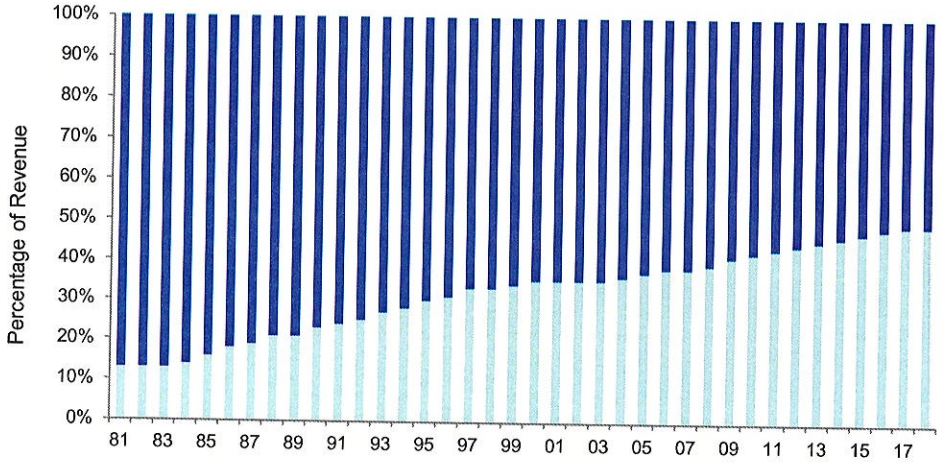
Care and revenue have shifted significantly toward outpatient.



Gross Inpatient Revenue (51%)

Gross Outpatient Revenue (49%)

Source: Analysis of American Hospital Association Annual Survey data, 2018, for community hospitals.

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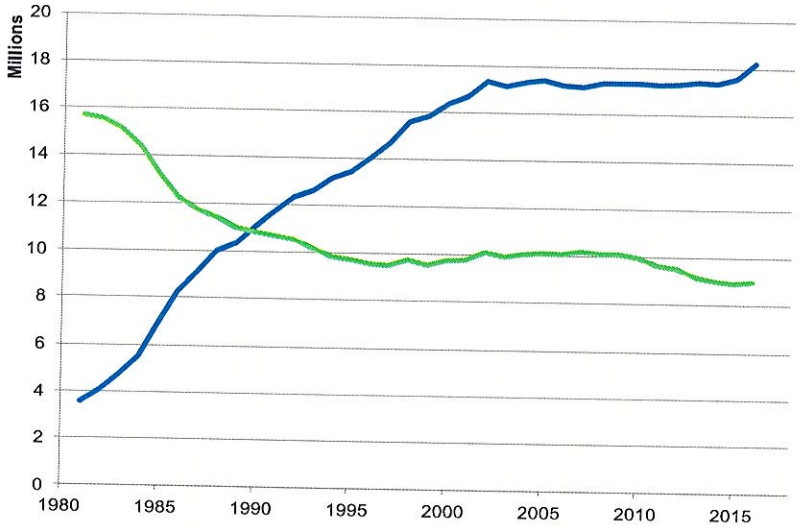
The shift in surgery was even greater.



OP surgeries accounted for 18% of all surgeries in 1981, 67% in 2016.

Source: Avalere Health analysis of American Hospital Association Annual Survey data, 2016, for community hospitals.

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Hillside Hospital: Physician-Led Planning (Part A)

The CEO's Dilemma

Introduction

Bill Hurt, the CEO of Hillside Hospital, stared out the window into the hurricane. "Great," he thought, "a day lost struggling with the logistical problems of a storm, while I have a bigger one brewing inside." Bill had been appointed CEO six months earlier, in March 2013. By September, he understood that the situation was worse than he had thought, and things were heating up.

Hillside had been under pressure for some time both from competing hospitals and from free-standing entities. In 2013, the combined pressure of these two forces began to take a major toll. Service volumes and market share dropped precipitously, and the forecast was for things to get even worse.

The direct causes of the volume declines were numerous—new hospitals in the service area, new programs at existing hospitals, and new free-standing facilities, some physician-owned and some operated as joint ventures with other organizations. But an indirect cause of the declines, and a major barrier to addressing them, lay in the relationship between Hillside management and the physicians on the medical staff.

Background

Hillside was a 300+ bed full service general hospital located six miles south of Riverbend, a large city in a southeastern state. Hillside was built in 1930 as a not-for-profit hospital under the aegis of the Trinitarians, a religious organization that had health care as one of its primary missions. The organization now owned and operated 38 hospitals in 10 states, including three other hospitals within 15 miles of Riverbend. Rather than run the hospitals centrally, the Trinitarians had developed unique local arrangements to provide management services to its individual hospitals.

The Trinitarian hospitals in the Riverbend area were managed by an organization called Value Health, a not-for-profit management company that was a joint venture between ProSantis, a Catholic hospital system, and the Trinitarians (see **Figure 1**). Each system had 50% representation on the Value Health board. Value Health provided a variety of management and financial services on a contract basis and appointed the CEO's of the individual hospitals.

However, each of the hospitals retained operational autonomy. Bill Hurt had been appointed CEO of Hillside Hospital by Value Health and reported to Alan Richardson, the CEO of Value Health.

Hillside had been under Value Health management since 2005. Hillside had 35 departments encompassing a broad range of secondary and tertiary services, including obstetrics, a 24-hour emergency department, a Level II nursery, an FAA-approved heliport, a full-service cardiovascular program, behavioral health, breast care services, a sight center, bimolecular imaging center/PET scanner, and transplant services. It co-sponsored with a hand surgery group practice the largest hand surgery service in the state, often cited by the hospital and the participating surgeons as a model of financial and clinical collaboration.

The Competitive Environment

When Hillside was built decades ago, it was on the outskirts of Riverbend. It benefited over the years from the growth of the city out to and beyond its primary service area. Historically, population growth served as a substitute for a proactive growth strategy. Now, however, the greatest continued growth was south of Hillside's primary service area. The population in Hillside's core service area, which included the hospital's zip code and contiguous zip codes, was growing more slowly. Two new facilities that had recently opened to the south of Hillside were expected to capture a significant share of the demand in the southern fringe, effectively reducing Hillside's primary service area in the future. **Table 1** shows the projected population growth in Hillside's primary service area by age category.

There were 12 other hospitals in the Hillside market area, including three owned by the Trinitarians and two owned by ProSantis. Valley Hospital, owned by HCA, a for-profit hospital chain, was its closest competitor, within one mile of Hillside. The next closest hospital was Lawndale, one of the three owned by the Trinitarians and part of the Value Health system. Many of Hillside's medical staff admitted to all three hospitals. Hillside was characterized as different from Valley because of its religious connection; as one physician described it, Hillside was "calmer, more spiritual, and had a lot of history," while Valley was "much more bustle and chaos." However Valley had a much better track record in terms of collaborating with physicians on joint ventures and upgrading hospital operations such as IT systems.

In 2012, Valley had a 17.7% market share in the primary service area (measured by share of total admissions), while Hillside had 12.8%, down from 13.2% in 2010. Two other hospitals had a market shares greater than 10%, while the remaining eight hospitals had market shares of less than 10%.

Payer mix in the service area was dominated by managed care organizations. Hillside had a relatively higher share of Medicare and lower share of commercial business than the average competitor hospital (see **Table 2**).

For the most part, Hillside compared favorably to its competitors in inpatient quality of care (see **Table 3**). However, a significant feature of the health care system in Riverbend was the

large number of free-standing diagnostic or treatment facilities[1], often owned by physicians or by physicians in partnership with a hospital. Since the state eliminated its certificate of need law, such facilities and joint ventures were fueling significant competition for hospitals, notably for ambulatory surgery. An analysis of market trends in ambulatory surgery showed that Hillside was losing market share to these facilities (see **Table 4**).

Hillside's Physicians

According to community surveys, the physicians admitting to Hillside were generally well-regarded. They provided many specialty and subspecialty services such as transplant surgery, cardiac surgery, invasive imaging, and others often associated with tertiary facilities.

However, primary care physicians were increasingly detached from the hospital as they admitted fewer patients and relied on hospitalists[2] to follow those patients they did admit. The primary care physicians rarely came to the hospital and therefore were less involved in medical staff activities at the hospital.

The six hospitalists on the medical staff admitted 14% of the total cases during the three-year period from FY2010–FY2012. Admissions were fairly concentrated, with only a small percentage of the total medical staff of 900 physicians generating the majority of the admissions. The top five admitters during FY2010–2012 (three of them hospitalists) accounted for 15.9% of all admissions; the top 40 admitters accounted for 61.2%. Over 50% of the hospital's admissions occurred through the Emergency Department (ED), including 63% of all cardiac admissions.

Recently a cardiology group left Hillside to set up their own free-standing cardiac catheterization lab. A couple of years before, the Hillside gastroenterologists started offering endoscopy services in their own facility. As the lead gastroenterologist explained, "The administration did not want to do a joint venture with us because they felt they already had all the volume, so why share it? After 34 years of negotiating with administration and getting nowhere, we walked out and did our own gastroenterology lab. We are doing it better than the hospital could, and now are up to seven doctors, from starting with four. Everyone has plenty of work."

Financial Performance

The financial position of Hillside Hospital was strong; however, in 2012, operating expenses grew faster than operating revenues, causing a sharp decline in operating margin (see **Table 5**). Contribution margins for the five highest and five lowest contributing services are shown in **Table 6** by inpatient and outpatient site. Profit margins by payer type, also by inpatient and outpatient site, are shown in **Table 7**.

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[1] These facilities were independent, separately licensed facilities not operating under a hospital's license or control.
[2] Hospitalists are physicians whose primary professional focus is the general medical care of hospitalized patients. They provide inpatient care to patients admitted by primary care physicians and refer those patients back to their customary primary care practitioner on discharge.

Although Hillside was profitable, there had been little money available for capital spending in recent years. Value Health retained a portion of earnings for corporate expenses, and the balance of free cash flow went back to the owners (Trinitarians). The owners then allocated some or all of this back as capital for reinvestment in the facilities. During the decade 2000–2010, the Trinitarian holdings under Value Health experienced severe financial problems due to unsuccessful investments in physician practices and managed care programs. Thus, as a group, they were not generating any free cash, so there were no funds available for capital expenditures. But by 2010, with the help of external consultants, Value Health completed a financial turnaround and cash started flowing back to the owners. In 2013, the Trinitarians expressed their willingness to make up to $120 million available for investment in what was being called the New Hillside. The Trinitarians looked to the hospital and to Value Health to develop a strategy to invest the available money.

Strategic Planning During 2012

A strategic plan was developed in 2012 by a consulting firm suggested by Value Health. After examining the basic demographic, service-related, and financial information, it had identified a number of reasonable strategies for Hillside to pursue. Key among them were:

Service Line Strategies

- Become known as the hospital for cardiology in South Riverbend
- Focus on growth in surgical cases (general, orthopedics, and others)
- Decide on the future of obstetrics at Hillside
- Make a move now to grow oncology
- Differentiate the Emergency Department (ED) on service quality
- Develop a Neuro Center of Excellence (with emphasis on strokes)

Non-Service Line Specific Strategies

- Maintain and grow Medicare (and pre-Medicare) market share
- Enable physician success

Based in part on these recommendations, a decision was made to a build a new Emergency Department (ED) to address what everyone agreed was one of the hospital's biggest weaknesses. The current ED was too small, hard to enter, and had poor access to diagnostic services. Since a large percentage of Hillside's admissions came through the ED, an attractive and accessible facility was crucial. A new parking garage was also planned to help support improved ED access.

The ED and parking garage initiatives were easy to accomplish—they were mainly bricks and mortar. The question was whether the rest of the recommendations could be implemented. They involved building services and required the engagement and support of the physicians. Unfortunately, the strategic planning process had made a disturbing finding: that the physicians at Hillside felt disenfranchised, disengaged, and disenchanted with the leadership at the hospital and the management company.

The Crisis At Hand

In 2013, the combined competitive pressures diverted significant patient volume from Hillside. Hillside lost ground in nearly every major service category. Much of the lost volume comprised outpatient procedures, which dropped 25% in the past five years, with 60% of the drop occurring since FY12. Surgical cases, which had been declining steadily since FY07, were projected to fall another 11% between FY12 and FY14. ED visits also were declining, although not as sharply as other categories; there was an expectation that ED visits would rebound with the opening of the new emergency facility. Inpatient admissions, which had been increasing, were projected to decline by 19% from FY12–FY14. Hillside's overall market share declined to 11.7% in FY13.

The one bright spot was a projected increase in deliveries due to a new family practice residency relationship. However, since most of the admissions were expected to be Medicaid-covered, there was a concern that the overall financial impact would be negative.

Hillside Leadership

Bill Hurt was the latest of a series of CEOs that Value Health had appointed to Hillside. Over the past six years there had been three different CEOs, with a six-month gap between the departure of the last one and Bill's appointment. During that period, Alan Richardson, acting as interim administrator, had hired a consultant to pursue the physician issues that the strategic planning consultants had identified and to help develop a plan to recruit and retain medical staff. That consultant carried out 96 meetings with Hillside physicians from August 2012 through January 2013. The results of those interviews reported that physicians had lost confidence in the executive leadership at Hillside and Value Health. The physicians felt overwhelmed by market challenges and revenue losses in their practices and were looking to hospitals to address their economic concerns, through development of alternative revenue sources and partnering. But they felt that the management at Hillside and Value Health lacked the vision and capacity to see and take advantage of opportunities. The physicians saw management as inaccessible and reactive, with a decision-making process that was lengthy, unclear, and involved little physician input.

Bill agreed with many of their observations. He knew that Value Health had been a cautious manager, quick to protect assets and slow to support change. He acknowledged that Hillside had some major weaknesses, including an aging medical staff, a shortage of primary care physicians, an unclear strategy (including regarding joint ventures with physicians), an aging physical plant, and outmoded information technology. Hillside also had a low profile in the community; market research showed that 53% of the people in the service area didn't recognize the hospital's name. On the other hand, he believed that Hillside had many strengths, including its faith-based mission, high quality physicians, strong clinical services, and reasonable financial performance.

He needed to find a way to keep the physicians engaged while the hospital's problems were worked out. Because of the level of disengagement and the highly competitive environment, he felt that he had to go beyond normal approaches to engage the physicians. The question was

how far he could go and still retain the focus and control the hospital required to operate effectively and move forward.

A Potential Approach

One of Bill's senior management team brought up a presentation she had seen by a consultant who advocated turning the hospital clinical planning process over to the physicians, with management involved as support only at the request of the physicians. The idea had intrigued her at the time (mainly because it challenged all her assumptions about working with physicians) and she offered to put Bill in touch with Charles Collins, the consultant she had met.

Bill read the materials that Charles sent him and was interested. Charles and his colleagues advocated an approach they called "Physician-Led Clinical Priority Setting" (see **Exhibit 8**) which used a process called "structured dialogue." They argued that most planning processes are hospital-centric and not in a format or process comfortable for physicians. The consultants believed that their process was more effective because it acknowledged the role and influence of physicians and engaged them in identifying and solving problems that were important to them. The hospital CEO's role in their model was limited to appointing the two physician co-chairs of the Medical Advisory Panel (MAP) that would then become responsible for determining its own membership and agenda, with the goal of making strategic recommendations for clinical services. The consultants argued that a limited role for senior management would force the physicians on the MAP to come up with solutions, whereas "if you (the CEO) are there, the physicians will ask you to fix all problems rather than owning the problem themselves."

Bill was intrigued. He began to talk about the program to others to gauge their reaction.

One of the first people he talked to was Alan Richardson, the CEO of Value Health. Alan had been the interim CEO at Hillside, so he was very familiar with the hospital and its staff. Alan thought the physicians were a loyal group who were looking for answers and needed support. But he expressed concern with the proposed approach. He thought the model went too far in turning over control of the process to the physicians. It essentially excluded management at the beginning and didn't provide a clear way for management to participate. He was also concerned that an outside consultant could end up creating a bigger problem than currently existed, in particular a more polarized medical staff. He felt that there were other less risky options that would be just as effective in engaging physicians to come up with solutions.

While Alan was worried about losing control, Bill thought sometimes you got power by giving it up. He continued to talk to his senior managers and to the medical leadership to get a sense of what the issues would be if he decided to go ahead.

Figure 1: Value Health Organization Chart

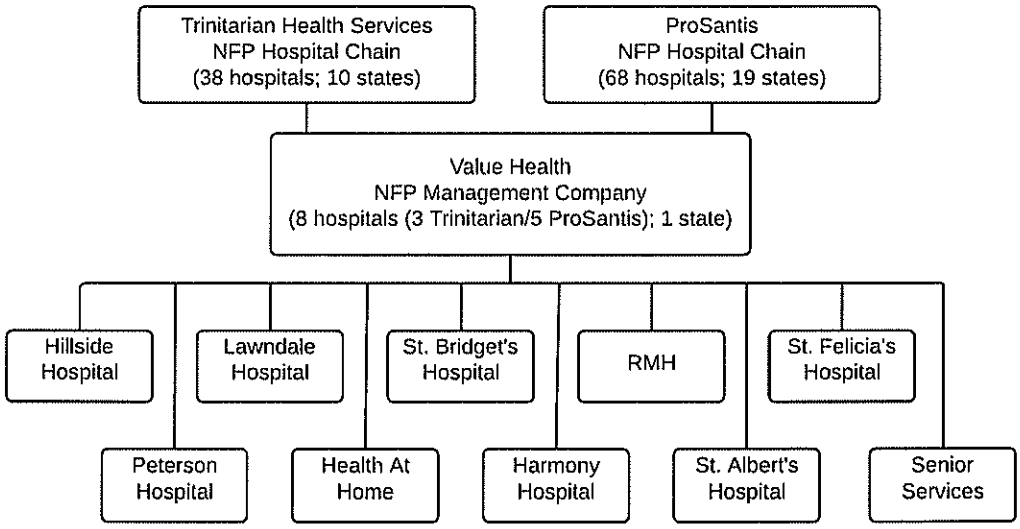

Table 1: Projected Population Growth in Hillside Primary Service Area, 2012–2017

Age	2012 Population	2017 Population	Growth	% Growth	Additional Annual Admissions	To Hillside
0-17	234,828	246,581	11,753	5.0%	450	7
18-44	369,382	371,876	2,494	0.7%	212	15
45-64	230,311	278,332	48,021	20.8%	5,633	669
65+	104,904	121,279	16,375	15.6%	5,980	1,442
Total	939,861	1,017,351	78,643	8.3%	12,275	2,134
					Lost to new hospitals	1,148
					Balance	986

Table 2: Payer Mix, Hillside Primary Service Area, 2012

	Service Area	Hillside Hospital	Valley Hospital
Payer			
Commercial	14.6%	4.1%	11.0%
HMO/PPO	47.6%	57.8%	56.1%
Medicaid	4.8%	1.9%	3.8%
Medicare	19.7%	31.6%	23.0%
Self-Pay	11.4%	4.2%	5.0%
Other	1.9%	0.4%	1.1%
Total	100.00%	100.00%	100.00%

Table 3: Health Grades Rankings of Hillside and Major Competitors

	Hillside	Valley	St. Joan's	MSM	RMH	University	Lake
Cardiovascular							
Heart Failure - Open Heart	★★★	★★★	★★★★★	★★★★★	★★★★★	★★★	★★★★★
Heart Attack - Open Heart	★★★★★	★★★	★★★★★	★★★	★★★	★★★	★★★★★
Valve Replacement	★★★		★★★	★★★	★★★	★★★	
Interventional Procedures	★★★	★★★	★★★	★★★	★★★	★	★★★
Coronary Bypass	★★★	★★★	★★★	★	★★★	★★★	★
Neurosurgery							
Stroke	★★★	★★★★★	★★★★★	★★★	★★★	★★★	★★★★★
Back & Neck Surgery (Spinal Fusion)	★	★★★	★★★	★	★★★		
Back & Neck Surgery (Except Spinal Fusion)		★★★	★★★	★★★	★★★	★★★	★★★
Orthopedics							
Total Knee Replacement	★★★	★	★★★	★★★	★★★	★★★	★★★
Total Hip Replacement	★★★	★★★	★★★	★★★	★★★	★★★	★★★
Pulmonary							
Aspiration Pneumonia	★★★★★	★★★	★★★	★★★	★★★★★		★★★★★
Community Acquired Pneumonia	★★★	★★★★★	★★★★★	★★★★★	★★★	★★★★★	★★★★★
COPD	★★★★★	★★★	★★★	★★★	★★★	★★★	★★★
Respiratory Infection	★★★		★★★	★★★	★★★		★★★★★

Table 4: Analysis of Changes in Ambulatory Surgery Volume and Market Share, 2010–2011

Hospital	2010	2011	Grand Total	Absolute Change	Percent Change	Market Share 2010	Market Share 2011
Valley	12,193	11,925	**24,110**	-268	-	16.62	15.52
Hillside	12,500	11,701	**24,220**	-799	-	17.04	15.23
Lake Medical	7,834	9,502	17,336	1668	21.3%	10.68	12.37
Lawndale	9,296	8,676	**17,330**	-620	-	12.67	11.29
Med Ctr of Deerfield	7,039	7,215	14,254	176	2.5%	9.59	9.39
MSM	3,467	5,216	8,683	1749	50.4%	4.72	6.79
St. James	3,535	4,143	7,678	608	17.2%	4.82	5.39
RMH	3,670	3,528	7,198	-142	-	5.00	4.59
St. Joan's Medical	3,512	3,463	6,975	-49	-	4.79	4.51
Bian	2,262	3,117	5,379	855	37.8%	3.08	4.06
Children's Hospital	2,748	2,766	5,514	18	0.7%	3.75	3.60
University	1,876	2,570	4,446	694	37.0%	2.56	3.34
Southeast Med Center	1,921	1,243	3,164	-678	-	2.62	1.62
St. Felicia Hospital	423	437	860	14	3.3%	0.58	0.57
South Suburban	287	356	643	69	24.0%	0.39	0.46
Southeast Rehab	30	210	240	180	600.0%	0.04	0.27
Peterson	117	125	242	8	6.8%	0.16	0.16
Santa Maria Medical	72	95	167	23	31.9%	0.10	0.12
Mountain Community	73	74	147	1	1.4%	0.10	0.10
All	522	481	1,003	-41	-	0.71	0.63
Grand	73,377	76,843	150,220	3466	4.7%	100.00	100.00

Table 5: Financial Trends, Hillside Hospital, FY2010–2012 ($000s)

	FY2010	FY2011	FY2012
Inpatient Gross Revenue	$379,628	$458,282	$462,050
Outpatient Gross Revenue	$166,746	$206,730	$221,603
Total Gross Revenue	$546,375	$665,010	$683,654
Net Revenue	$211,013	$243,314	$256,064
Operating Expense	$187,344	$218,154	$235,509
Net Income	$23,669	$25,160	$19,610
Operating Margin	11.22%	10.34%	7.66%

Table 6: Contribution Margin (CM) and Profit Margin by Major Inpatient and Outpatient Service 2012

Five Highest Contributor Services							
Inpatient	**CM per Case**	**Profit Margin**	**Service Net Inc**	**Outpatient**	**CM per Case**	**Profit Margin**	**Service Net Inc**
Cardiology	$3,998	11.0%	$3.1M	Radiology	$285	57.1%	$4.5M
Pulmonary	$2,952	15.5%	$1.0M	ER—No Trauma	$430	47.2%	$3.7M
Oncology	$3,331	4.1%	$0.4M	OP/Day Surgery	$726	32.7%	$3.7M
Neurology	$2,081	6.7%	$0.3M	Pre-Op Exam	$1,223	44.4%	$2.9M
Hepatobiliary/Pancreas	$2,658	6.4%	$0.2M	Oncology	$945	29.4%	$1.8M
Five Lowest Contributor Services							
Inpatient	**CM per Case**	**Profit Margin**	**Service Net Inc**	**Outpatient**	**CM per Case**	**Profit Margin**	**Service Net Inc**
OB/Neonate Level 1	($257)	-1.5%	$(2.1M)	Breast	$22	-36.8%	$(0.2M)
Orthopedics	$2,203	-11.5%	$(1.0M)	Diabetes*	$12	-446.0%	$(5K)
Neonate Level II	($3,494)	-83.7%	$(0.9M)	Observation*	$387	-6.1%	$(4K)
Urology	$916	-18.5%	$(0.3M)	Pharmacy*	$341	29.8%	$7K
Substance Abuse	$225	-43.5%	$(0.3M)	Lab	$100	29.3%	$17K
Total—All Services	**$2,153**	**(1.5%)**	**$(1.5M)**		**$399**	**36%**	**$21.1M**

*very small volumes

Table 7: Margin by Payer and Category of Care, Hillside Hospital, FY2011

	% Inpt Payments	**Inpatient Margin**	**% Outpt Payments**	**Outpatient Margin**	**% Total Payments**	**Total Margin**
Indemnity Insurance	9%	46.4%	11%	63.0%	10%	53.6%
Managed Care	36%	7.9%	65%	49.0%	47%	29.1%
Workers Comp			2%	53.2%	1%	53.2%
Medicaid Managed Care	1%	-7.3%	1%	37.1%	1%	9.5%
Medicaid	2%	-35.2%	1%	3.4%	1%	-25.9%
Capitated Medicare*	17%	-45.6%	8%	-26.8%	13%	-41.6%
Medicare	34%	2.6%	11%	-30.1%	25%	-2.7%
Self-Pay	0.4%	-423.3%	1%	-73.0%	1%	-221.7%
Other	1%	44.0%	0.4%	32.1%	1%	42.1%
Total	100%	-1.5%	100%	34.6%	100%	12.0%

*converted to a fee-for-service program as of 1/1/13

Exhibit 8: Physician-Led Clinical Priority Setting
A Brief Description

Overview

Physicians control the major decisions that impact costs, quality, efficiency, and satisfaction. Yet the role of physicians in major strategic, policy, and operating decisions is frequently not well-organized or consistent. Efforts that try to enlist the support of physicians through inclusion on administrative and governance committees and boards tend to be hospital-centric and fall short of responding to the full range of needs of physicians in their practice.

The Clinical Priority Setting process engages physicians in a physician-led, peer-reviewed, structured dialogue that enables them to become leaders in clinical decision-making and development. The participative process provides the opportunity for all physicians who wish to participate to have their views, opinions, and recommendations heard and considered. The advantage of the Clinical Priority Setting process is that it acknowledges the role and influence of physicians. The process is designed to address physician-specific issues including:

- responding to the health care needs of the community
- enhancing physician practices economically and clinically
- improving relationships among physicians
- ensuring closer alignment between the hospital and its medical staff

The Process—How It Works

The diagram on the next page illustrates the steps in the Clinical Priority Setting process. The project is guided by a small group of physicians—the Medical Advisory Panel (MAP).

The MAP asks each clinical section to prepare a presentation that describes the current status of the section and activity levels and that sets forth the priorities for that section based on criteria developed by the MAP. Each clinical section presents to the MAP orally and in writing.

The responsibilities of the MAP include:

- providing overall guidance to the process and the individual clinical sections
- establishing criteria and guidelines for clinical section presentations
- encouraging breadth of participation by section members
- meeting with each clinical section and evaluating their proposals and recommendations
- evaluating and ranking recommendations presented by the clinical sections
- submitting prioritized final recommendations to management and the Board.

The final recommendations, of which typically three or four are ranked as "highest priority," are submitted to the Board and management together with a description of the recommendation, the justification for its high priority, and an estimate of the capital and operating costs associated with it. Typically, we have found that the recommendations focus on issues of service, satisfaction, and organization rather than high-cost capital programs.

Clinical Priority Setting Process